AMENDED IN SENATE APRIL 1, 2004

# SENATE BILL No. 1187

**Introduced by Senator Chesbro**

February 9, 2004

An act to amend Section 14132.100 of, and to add Sections 14132.101, and 14132.102 to, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1187, as amended, Chesbro. Medi-Cal: federally qualified health centers and rural health services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and other low-income persons.

Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed to providers on a per-visit basis, and would provide for various requirements pertaining to the reimbursement of these services. Existing law authorizes each FQHC or RHC to apply for an adjustment to the per-visit rate, and provides for the evaluation of rate change proposals based on a change in the scope of services, but prohibits a change in the costs to be considered a scope of service unless certain factors apply, defines visits for those purposes, and prescribes procedures and deadlines for submitting a scope-of-service change.

This bill would revise the scope of those factors applicable to a scope-of-service change for any FQHC or RHC filing a consolidated cost report for multiple sites, and would authorize those entities to

utilize a consolidated cost report in order to calculate costs associated with a scope-of-service change, and would revise the definition of a visit for those purposes.

~~This bill would require the direct reimbursement of any FQHC or RHC at the prospective payment rate for services provided at a location other than a site owned by the FQHC or RHC if certain conditions are met.~~

*This bill would establish various conditions that must be met for a FQHC or RHC that provides services at a location other than a site owned by the FQHC or RHC to be directly reimbursed for those services, which reimbursement would be either at the prospective payment rate or at a fee-for-service rate.*

This bill would provide that encounters with more than one health professional and multiple encounters with the same health professional that take place on a single day and at a single location constitute a single visit for reimbursement purposes, unless certain conditions apply.

~~This bill would require the department to conduct a study, and by January 1, 2005, to provide a report to the chairs of certain legislative committees on the feasibility of providing discounted prescription drugs to California's most vulnerable population.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d (a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accord with the definition of ''visit'' set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1~~,~~ thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index

applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accord with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Sec. 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in ~~subdivisions~~ *subdivision* (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHC's and RHC's filing consolidated cost reports for multiple sites, the FQHC's or RHC's rate equals or exceeds the lesser of 1.75 percent or ten thousand dollars ($10,000), on a aggregated basis. ''Net change'' means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 150 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 150 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 150 days of

the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, ''significantly lower'' means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to ''fiscal year'' shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(8) An FQHC or RHC may, but shall not be required to, utilize a consolidated cost report for multiple sites in order to calculate costs associated with a scope-of-service change under this subdivision. Rates and scope-of-service changes for all sites covered by the report shall be increased or decreased in the aggregate for FQHC's and RHC's filing consolidated reports.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS

rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include all of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant (two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less).

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) An FQHC or RHC ''visit'' means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, ''physician'' shall be interpreted in a manner consistent with the Medicare definition of ''physician'' as set forth in subsection (r) of Section 1395x of Title 42 of the United States Code, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as

defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare program, or the Child Health and Disability Prevention (CHDP) program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the

prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the

mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-services adjustments as provided in subdivision (e).

(*l*) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, by no later than March 30, 2004, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

SEC. 2. Section 14132.101 is added to the Welfare and Institutions Code, to read:

~~14132.101. (a) With respect to services provided by an FQHC or RHC at a location other than a site owned or operated by the health center or clinic, the FQHC or RHC shall be directly reimbursed at the prospective payment rate for all such services, where each of the following conditions are met:~~

*14132.101. (a) Services provided by a FQHC or RHC at a location other than a site owned or operated by the health center or clinic shall be reimbursed pursuant to this section.*

*(b) A FQHC or RHC described in subdivision (a) that meets all of the following conditions shall be directly reimbursed at the*

*prospective payment rate for services provided by that center or clinic:*

(1) The services are delivered to a patient of the FQHC or RHC.

(2) The services are provided by a health care provider who is an employee or independent contractor of the FQHC or RHC pursuant to the terms of a written contract to deliver those services.

(3) The health care provider delivering the services is a primary care physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this subdivision, ''primary care physician'' means an internist, family practitioner, general practitioner, pediatrician, or a health professional listed in paragraphs (2) to (5) inclusive, of subsection (r) of Section 1395x of Title 42 of the United States Code.

(4) With respect to FQHC services only, the services are within the scope of project approved by the Health Resources and Services Administration, to the extent the approval is required by federal law.

~~(b) FQHCs and RHCs shall be directly reimbursed on a fee-for-service basis for any service provided by a specialist to an FQHC or RHC patient while the patient is a hospital inpatient. For~~

*(c) A FQHC or RHC described in subdivision (a) that meets all of the following conditions shall be directly reimbursed at the fee-for-service rate, and not at the prospective payment rate, for services provided by that center or clinic:*

*(1) The services are delivered to a patient of the FQHC or RHC.*

*(2) The services are provided by a health care provider who is an employee or independent contractor of the FQHC or RHC pursuant to the terms of a written contract to deliver those services.*

*(3) The health care provider is a specialist. For* the purposes of this subdivision, ''specialist'' means any physician who is board certified or board eligible for a specialty other than, or in addition to, family practice, pediatrics, or internal medicine. Costs, visits, and income associated with ~~those services~~ *specialist services, as described in this subdivision,* shall be excluded from the cost reports required under Section 14132.100.

SEC. 3. Section 14132.102 is added to the Welfare and Institutions Code, to read:

14132.102. (a) Encounters with more than one health professional and multiple encounters with the same health

professional that take place on the same day and at a single location constitute a single visit, except when one of the following conditions exists:

(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

(2) For FQHCs *and RHCs*, the patient has a ''medical visit'' and an ''other health visit,'' as defined in subdivision (c).

(b) Medi-Cal shall pay for two visits per day when the conditions in subdivision (a) are met. In all other cases, payment is limited to one visit per day.

(c) For purposes of paragraph (2) of subdivision (a), ''medical visit'' means a face-to-face encounter between an FQHC *or RHC* patient and a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse and ''other health visit'' means a face-to-face encounter between an FQHC *or RHC* patient and a dentist, clinical psychologist, clinical social worker, or psychiatrist for mental health services.

~~SEC. 4. (a) (1) The State Department of Health Services shall conduct a study, by July 1, 2005, on the feasibility of providing discounted prescription drugs to California's most vulnerable patient populations through Section 256 of Title 42 of the United States Code.~~

~~(2) The department shall provide a report to the Chair of the Joint Legislative Budget Committee and the Chairs of the Senate Committee on Health and Human Services and the Assembly Committee on Health on the results of the study required by paragraph (1).~~

~~(b) The department shall work with other state agencies, representatives of state employees, and representatives of health care providers and facilities in the state to provide the following information:~~

~~(1) A description of all health care providers and facilities in the state potentially eligible for designation as ''eligible entities'' under subsection (b) of Section 256 of Title 42 of the United States Code, including, but not limited to, hospitals eligible as disproportionate share hospitals; recipients of grants from the United States Public Health Service; federally qualified health centers; federally qualified health center look-alikes; state-operated AIDS drug assistance programs; under the federal Ryan White Comprehensive AIDS Resources Emergency~~

~~(CARE) Act of 1990 (Public Law 101-381), as amended, Title I, Title II, and Title III programs; tuberculosis, black lung, family planning and sexually transmitted disease clinics; hemophilia treatment centers; public housing primary care clinics; and clinics for homeless people.~~

~~(2) A listing of potential applications of Section 256 of Title 42 of the United States Code and the potential benefits to public, private, and third-party payers for prescription drugs, including, but not limited to, the following:~~

~~(A) Application to inmates and employees in youth correctional facilities, county jails, and state prisons.~~

~~(B) Maximizing the use of Section 256 of Title 42 of the United States Code within state-funded managed care plans.~~

~~(C) Including providers eligible for federal grants under subsection (b) of Section 256 of Title 42 of the United States Code in state bulk purchasing initiatives.~~

~~(D) Utilizing sole source contacts with providers eligible for federal grants under subsection (b) of Section 256 of Title 42 of the United States Code to furnish high-cost chronic care drugs.~~

~~(3) Discounts available through contracts complying with Section 256 of Title 42 of the United States Code, including estimated costs savings to the state as a result of retail markup avoidance, negotiated subceiling prices, and coordination with the Medi-Cal program in order to minimize costs to the program and to other purchasers of prescription drugs.~~

~~(4) Resources available to potential applicants for designation as eligible entities for the application process, establishing a program complying with Section 256 of Title 42 of the United States Code, restructuring the health care system or other methods of lowering the cost of prescription drugs. The resources shall include state and federal agencies and private philanthropic grants to be used for the purposes of this section.~~

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